AMENDED IN ASSEMBLY JULY 15, 2003

AMENDED IN ASSEMBLY JUNE 30, 2003

AMENDED IN SENATE JUNE 3, 2003

AMENDED IN SENATE APRIL 29, 2003

AMENDED IN SENATE APRIL 10, 2003

# SENATE BILL No. 130

**Introduced by Senator Chesbro**

February 5, 2003

An act to add Division 1.5 (commencing with Section 1180) to the Health and Safety Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 130, as amended, Chesbro. Health and care facilities: use of seclusion and behavioral restraints.

Existing law provides for the licensure and regulation of health facilities, including various types of hospitals that provide mental health treatment services, by the State Department of Health Services.

Existing law, the California Community Care Facilities Act, provides for the licensure and regulation of community care and residential facilities by the State Department of Social Services. Existing law authorizes these facilities to provide mental health treatment services.

Under existing law, the State Department of Mental Health is charged with the state administration of state hospitals for the mentally disordered.

Under existing law, these facilities are authorized to provide secure containment or use seclusion and restraints, as specified, on patients.

This bill would require the California Health and Human Services Agency to provide leadership and coordination necessary to reduce the use of seclusion and behavioral restraints in facilities that are licensed, certified, or monitored by departments that fall within its jurisdiction.

This bill would require the secretary to develop technical assistance and training programs to support the efforts of facilities to reduce or eliminate the use of seclusion and behavioral restraints in facilities, and to take steps to ensure a system of data collection.

This bill would authorize specified facilities to use seclusion and behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to the person or others, would require an initial assessment of each person upon admission for these purposes, and would prohibit specified facilities from using specified types of seclusion and behavioral restraints. This bill would also require these facilities to conduct reviews, as specified, for each episode of the use of seclusion or behavioral restraint, to conduct debriefings, as specified, and to document the incident. This bill would also require these facilities to report, as specified, each death or serious injury occurring during, or related to, the use of seclusion or behavioral restraints.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

SECTION 1. The Legislature finds and declares all of the following:

(a) The use of seclusion and behavioral restraints is not treatment, and their use does not alleviate human suffering or positively change behavior. In addition, when used, they are dangerous and dehumanizing.

(b) Inactivity, boredom, and confinement in noisy and crowded wards are significant contributors to frustration, conflict, and stress in facilities, and lead to the problem of the use of seclusion and behavioral restraints.

(c) An ongoing commitment to varied, active, and stimulating choices of programming is important in addressing the problems of the use of seclusion and behavioral restraints in facilities.

(d) The commitment of managers and staff of facilities is essential to changing the culture of those facilities and reducing the

use of seclusion and behavioral restraints, and providing a safer and more therapeutic environment for mental health patients and staff in California.

(e) In order to achieve the goal of a reduction in the use of seclusion and behavioral restraints, California must utilize the best practices developed in other states, and use the most efficient modern resources to accomplish these goals, including computerized data collection and analysis, public access to this information on the Internet, strategies for organizational change, staff training in risk assessment, crisis prevention and intervention, patient debriefing models, and recovery-based treatment models.

(f) Adequate numbers of staff are essential to reducing seclusion and behavioral restraints in facilities; however, California faces a human resource crisis in mental health care. According to the California Mental Health Planning Council, vacancy rates for mental health positions in California exceed 30 percent. The Employment Development Department estimates that between 1998 and 2008, public and private providers will need to fill 45,000 mental health positions. To address this crisis, the Little Hoover Commission has called for coordinated, integrated, and success-oriented strategies such as hiring clients, recruitment efforts, training academies, scholarships and loan forgiveness, workload analysis, and ensuring training in core competencies. The Legislature finds that resolving California's mental health workforce crisis is important to the goal of reducing seclusion and behavioral restraints in California facilities.

(g) It is the intent of the Legislature in enacting this act to achieve a reduction in the use of seclusion and behavioral restraints in facilities in California.

SEC. 2. Division 1.5 (commencing with Section 1180) is added to the Health and Safety Code, to read:

## DIVISION 1.5. USE OF SECLUSION AND BEHAVIORAL RESTRAINTS IN FACILITIES

1180. (a) The California Health and Human Services Agency, in accordance with their mission, shall provide the leadership and coordination necessary to reduce the use of seclusion and behavioral restraints in facilities that are licensed,

certified, or monitored by departments that fall within its jurisdiction.

(b) This division shall apply to all facilities that utilize seclusion or behavioral restraints, including, but not limited to, state hospitals, the psychiatric units of general acute care hospitals, acute psychiatric hospitals, psychiatric health facilities, crisis stabilization units, community treatment facilities, group homes, skilled nursing facilities, intermediate care facilties, community care facilities, and mental health rehabilitation centers.

(c) For purposes of this division, the following definitions apply:

(1) ''Behavioral restraint'' means ''mechanical restraint'' or ''physical restraint'' as defined in this section, used as an intervention when a person presents an immediate danger to self or to others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure, or postural restraints, or devices used to prevent injury or to improve a person's mobility and independent functioning rather than to restrict movement.

(2) ''Containment'' means a brief physical restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others.

(3) ''Mechanical restraint'' means the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a person's body or restricts normal access to the person's body, and that is used as a behavioral restraint.

(4) ''Physical restraint'' means the use of a manual hold to restrict freedom of movement of all or part of a patient's body, or to restrict normal access to the patient's body, and that is used as a behavioral restraint. ''Physical restraint'' is any staff-to-patient physical contact in which the patient unwillingly participates. ''Physical restraint'' does not include briefly holding a person without undue force in order to calm or comfort, or physical contact intended to gently guide or assist a person from one area to another.

(5) ‘‘Seclusion’’ means the involuntary confinement of a person alone in a room or an area from which the resident is physically prevented from leaving.

(6) ‘‘Secretary’’ means the Secretary of the California Health and Human Services Agency.

(7) ‘‘Serious injury’’ means any significant impairment of the physical condition as determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs, whether self-inflicted or inflicted by someone else.

(d) (1) The agencies or entities specified by the secretary, at the request of the secretary, shall provide information to the secretary regarding efforts undertaken to reduce the use of seclusion and behavioral restraints, including, but not limited to, efforts to pursue federal funding for this purpose.

(2) As funds become available, the secretary or his or her designee shall develop technical assistance and training programs to support the efforts of facilities to reduce or eliminate the use of seclusion and behavioral restraints in those facilities that utilize them. Technical assistance and training programs should be designed with the input of clients and direct care staff and should be based on best practices that lead to reduced use of seclusion and behavioral restraints, including, but not limited to, the following:

(A) Assessment of underlying reasons for the escalated behavior.

(B) Avoidance and management of crisis situations.

(C) Treatment planning that identifies risk factors, positive early intervention strategies, and strategies to minimize time spent in seclusion or behavioral restraints.

(D) Conflict resolution, deescalation, and client-centered problem solving strategies that diffuse and safely resolve emerging crisis situations.

(E) Debriefing strategies that result in client and staff comfort in identifying factors that lead to seclusion or behavioral restraint and factors that would reduce likelihood of future seclusion or behavioral restraint occurrences.

(3) The secretary shall pursue federal and private funding to support the development of a training protocol that can be incorporated into the existing training activities for direct care

staff conducted by the state, facilities, and educational institutions to reduce the use of seclusion and restraints.

(e) Within existing resources, the secretary or his or her designee shall take steps to ensure a system of mandatory, consistent, timely, and publicly accessible data collection regarding the use of seclusion and behavioral restraints in all facilities described in subdivision (b) that utilize seclusion and behavioral restraints. In determining a system of data collection, the secretary should utilize existing efforts, and direct new or ongoing efforts, of associated state departments to revise or improve their data collection systems. The secretary should consider a mechanism to ensure compliance by facilities, including, but not limited to, penalties for failure to report in a timely manner. It is the intent of the Legislature that data be compiled in a manner that allows for standard statistical comparison and be maintained for each facility subject to reporting requirements for the use of seclusion and behavioral restraints.

(f) The secretary shall develop a mechanism for making this information publicly available on the Internet as soon as possible.

(g) Data collected pursuant to subdivision (e) shall include all of the following:

(1) The number of deaths that occur while a person is in seclusion or behavioral restraints, or where it is reasonable to assume that the death was proximately related to the use of seclusion or behavioral restraints.

(2) The number of serious injuries sustained by persons while in seclusion or subject to behavioral restraints.

(3) The number of serious injuries sustained by staff that occur during the use of seclusion or behavioral restraints.

(4) The number of incidents of seclusion.

(5) The number of incidents of use of behavioral restraints.

(6) The duration of time spent per incident in seclusion.

(7) The duration of time spent per incident subject to behavioral restraints.

(8) The use of involuntary emergency medication.

(h) Within existing resources, the secretary shall make recommendations for additional facilities or additional units or departments within facilities that should be included within the

requirements of this section, including, but not limited to, emergency rooms.

(i) Within existing resources, the secretary or his or her designee shall assess the impact of serious staff injuries sustained during the use of seclusion or behavioral restraints, on staffing costs and on workers' compensation claims and costs.

(j) Within existing resources, the secretary or his or her designee shall work with the state departments that have responsibility for oversight of seclusion and behavioral restraints to review and eliminate redundancies and outdated requirements in the reporting of data on seclusion and behavioral restraints.

1180.1. A facility described in subdivision (b) of Section 1180 shall conduct an initial assessment of each person upon admission to the facility, or as soon thereafter as possible. This assessment shall include input from the person and from a family member, significant other, or authorized representative designated by the person, if he or she desires, and if the desired third party can be present at the time of admission. This assessment shall also include all of the following:

(a) A person's advance directive regarding deescalation or the use of seclusion or behavioral restraints.

(b) Identification of early warning signs, triggers, and precipitants that cause a person to escalate, and identification of the earliest precipitant of aggression for persons with a known or suspected history of aggressiveness, or persons who are currently aggressive.

(c) Techniques, methods, or tools that would help the person control his or her behavior.

(d) Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion.

(e) Any trauma history, including any history of sexual or physical abuse that the affected person feels is relevant.

1180.2. A facility described in subdivision (b) of Section 1180 may use seclusion or behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others.

1180.3. (a) A facility described in subdivision (b) of Section 1180 may not use either of the following:

(1) A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back.

(2) A pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint or containment process.

(b) A facility described in subdivision (b) of Section 1180 may not use physical or mechanical restraint or containment on a person who has a known medical or physical condition, and where there is reason to believe that the use would endanger the person's life or exacerbate the patient's medical condition.

(c) A facility described in subdivision (b) of Section 1180 may not use prone mechanical restraint on a patient at risk for positional asphyxiation as a result of one of the following risk factors that are known to the provider:

(1) Obesity.

(2) Pregnancy.

(3) Agitated delirium or excited delirium syndromes.

(4) Cocaine, methamphetamine, or alcohol intoxication.

(5) Exposure to pepper spray.

(6) Preexisting heart disease, including, but not limited to, an enlarged heart and other cardiovascular disorders.

(7) Respiratory conditions, including emphysema, bronchitis, or asthma.

(d) A facility described in subdivision (b) of Section 1180 shall avoid the deliberate use of prone containment techniques whenever possible, utilizing the best practices in early intervention techniques such as deescalation. If prone containment techniques are used in an emergency situation, a staff member shall observe the patient for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the patient shall not be involved in restraining the patient.

(e) A facility described in subdivision (b) of Section 1180 may not place a patient in a facedown position with hands held or restrained behind the patient's back.

(f) A facility described in subdivision (b) of Section 1180 may not use physical restraint or containment as an extended procedure.

(g) A facility described in subdivision (b) of Section 1180 shall keep under constant, face-to-face human observation a person who is in seclusion and in any type of behavioral restraint at the same time.

(h) A facility described in subdivision (b) of Section 1180 shall afford to patients who are restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the patient and others, and must use the least number of restraint points.

(i) A person in a facility described in subdivision (b) of Section 1180 has the right to be free from the use of seclusion and behavioral restraints of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes, but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the patient's freedom of movement, if that drug is not a standard treatment for the patient's medical or psychiatric condition.

1180.4. (a) A facility described in subdivision (b) of Section 1180 shall conduct a clinical, administrative, and quality review for each episode of the use of seclusion or behavioral restraints.

(b) A facility described in subdivision (b) of Section 1180 shall, within 24 hours after the use of seclusion or behavioral restraints, conduct a debriefing regarding the incident with the person, and, if the person requests it, the person's family member, domestic partner, significant other or authorized representative, the staff members involved in the incident, and a representative of the senior or management staff of the facility, to discuss how to avoid a similar incident in the future. The person's participation in the debriefing shall be voluntary. The purposes of the debriefing shall be to do all of the following:

(1) Assist the patient to identify the precipitant of the incident, and suggest methods of more safely and constructively responding to the incident.

(2) Assist the staff to understand the precipitants to the incident, and develop alternative methods of helping the person avoid or cope with those incidents.

(3) Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan.

(4) Provide an opportunity for both persons and staff to assess the appropriateness and efficacy of staff response during the emergency, and attend to the person's feelings.

(5) Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and hospital policies.

(c) The facility shall, in the debriefing, provide both the patient and staff the opportunity to discuss the circumstances resulting in the use of seclusion or behavioral restraints, and strategies to be used by the staff, the person, or others that could prevent the future use of seclusion or behavioral restraints.

(d) The facility staff shall document in the patient's record that the debriefing session took place and any changes to the person's treatment plan that resulted from the debriefing.

1180.5. A facility described in subdivision (b) of Section 1180 shall report each death or serious injury occurring during, or related to, the use of seclusion or behavioral restraints. This report shall be made to the agency designated in *subdivision (h) of* Section 4900 of the Welfare and Institutions Code no later than the close of the business day following the death or injury. The report shall include the name of the person involved, and the name, street address, and telephone number of the facility.

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